



**NEW PATIENT INFORMATION**

**\*\*\*PLEASE GIVE ANY XR, CT, or MRI DISCS TO THE FRONT DESK\*\*\***

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ Circle: Male Female Gender Identity: \_\_\_\_\_

RACE \_\_\_\_\_ LANGUAGE \_\_\_\_\_ Circle: Hispanic Non-Hispanic

MARITAL STATUS: Single Married Divorced EMAIL \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

PHARMACY \_\_\_\_\_ PRIMARY CARE PHYSICIAN \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ SECONDARY INSURANCE \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

Are you at a Skilled Nursing Facility? NO YES, Name of Facility \_\_\_\_\_

If you have Medicare, are you working? NO YES If you have Medicare, are you disabled? NO YES

How did you hear about us? \_\_\_\_\_

<u>Fill this section out about your illness or injury</u>	
What is the reason for your visit today? _____	Circle: Left Right
What date did the injury happen? _____	
Where did it happen? (circle) SCHOOL HOME WORK AUTO CRASH OTHER _____	
Is this a worker's compensation injury? NO YES Was an incident report filed with supervisor? NO YES	
Is there legal action or an attorney concerning this injury? NO YES, attorney name _____	

<u>ONLY fill this section out if the patient is a CHILD or FULL TIME STUDENT</u>	
MOM'S NAME _____	DAD'S NAME _____
GUARDIAN NAME _____	RELATIONSHIP TO PATIENT _____

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I assign to Lowcountry Orthopaedics & Sports Medicine a member of Arcis Healthcare, LLC, all health insurance benefits available for services provided to me. I understand that fees for services provided by Lowcountry Orthopaedics & Sports Medicine a member of Arcis Healthcare, LLC, are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



**FINANCIAL POLICY FOR LOWCOUNTRY ORTHOPAEDICS (LCO), a member of ARCIS HEALTHCARE**

**Payment for Services**

Copays will be collected at check-in, along with any balance due on the account. We will pre-collect the estimated patient responsibility amounts for surgeries, procedures, and MRI services

**Insurance**

Insurance information will be updated yearly, and we may request your card at each visit. Please notify us of any change in carrier, coverage, or cards. Failure to disclose policy changes may result in claim denial, and financial charges will become the patient's responsibility. The patient is responsible for knowing the benefits and limitations of their insurance plan.

**Referrals**

LCO is a specialty practice. If your plan(s) require a referral from your primary care physician (family or regular doctor) for specialty services to be covered, please make sure one has been provided prior to your appointment. Patients who do not have the required referral can either reschedule or be self-pay.

**Copays, Deductibles, Co-insurance, and Payment for Services**

Any outstanding account balances will be collected at check-in. Many insurance plans require us to collect copays, deductibles, and coinsurance, and if these cannot be paid at the time of service, a \$10 processing fee will be added. In addition, we will collect payments for any services that insurance does not cover at the time of service. Prepayment is required for any estimated costs for surgeries, procedures, and MRIs. LCO does not take secondary payer adjustments. If you have a Health Savings Account, Health Reimbursement Account, or Flexible Spending Account, we will provide the necessary documentation for reimbursement; payment is still required at the time of service. The patient is responsible for any copays, deductibles, coinsurance, and any other services not covered, including Durable Medical Equipment (e.g., braces), casting, and drug screening.

**Uninsured Patients**

A \$300 deposit is required for all uninsured patients prior to the appointment. This deposit will be applied to the charges for the visit, and any overages must be paid in full at check-out. If you cannot pay the balance, a payment plan can be arranged.

**Past Due Balances**

Balances that are not paid within 30 days are considered in default. If your insurance company has not responded within 30 days, we may request your assistance in obtaining payment or request that you make a payment. Balances not paid within 90 days will be forwarded to a collections agency, and any associated fees will be added to your account. Any balances must be paid in full or placed on a payment plan before any additional services are rendered.

**No Show and Late Cancellation Fees**

If you cannot keep an office appointment, you must cancel at least 48 hours in advance, or a \$25 fee will be charged. Other fees for late cancellations/no shows include MRI (\$150), Epidural steroid injections (\$150), EMG/NCV (\$150), and surgical procedures (\$150).

**Disability or FMLA Forms**

A \$20 fee will be charged for EACH form completed by our legal department, and processing may take up to 15 days. Payment must be made, and the Claimant Information for Disability Benefits form must be submitted before any request is processed.

**Medical Records and Imaging**

LCO requires a Medical Records Release form to process your request. We use an outside company, RecordQuest, for medical records requests. You may contact them at 888-300-7410 or PO Box 2017, Mount Pleasant, SC 29465, or www.recordquest.com/contactus.aspx. Personal copies of X-ray and MRI will cost \$10 per disk and may take up to 48 hours to process. Medical records/images will be forwarded to another medical office at no cost.

**Electronic Prescribing**

LCO uses e-prescribing and may access my prescription history to provide the most accurate medication list.

**I understand that I am financially responsible for account balances, copays, deductibles, coinsurance, and any services not covered, including DME, drug screening, and casting.**

**I understand that I will be charged a fee for any missed appointments or late cancellations.**

**I understand there is a fee for personal copies of medical records and imaging, disability, or FMLA forms.**

# HIPAA PRIVACY AUTHORIZATION FORM

**Notice of Privacy Practice Summary:** All patients have the right to know that their Personal Health Information remains confidential. The Privacy Rights and Practices of Lowcountry Orthopedics were established to protect our patients' healthcare information, as required by Section 164.520 of the Health Insurance Portability and Accountability Act of 1996 and the 2026 Regulatory Updates. These guidelines restrict the release of your medical information for treatment, payment, and healthcare operations. Examples of agencies or facilities to which your PHI may be released:

- Health Insurance
- Physician Consults
- Pharmacies
- Surgical Facilities
- Lab Testing
- Physical Therapy
- Hospitals
- Physician Interns

**Other uses or disclosures permitted/required by law:** Public Health Activities; Reporting Abuse/Neglect; Health Inspection Agencies; Judicial Proceedings; Law Enforcement; Decedents; Workers' Comp; Public Health Safety; Military/Veterans' Activities. The full version of The Notice of Privacy Practices (Policy HIP 114) is available upon request at the front desk or online on our website. To assist our office with this process, please complete the following sections in full.

## 1. COMMUNICATION PREFERENCES

Can messages or appointment reminders be left on your: Select, Yes or No:

- |                |          |                   |          |
|----------------|----------|-------------------|----------|
| Voicemail      | Yes / No | Answering Machine | Yes / No |
| Family Members | Yes / No | Text Message      | Yes / No |
| Chart Sharing  | Yes / No | E-mail            | Yes / No |

If Yes to E-mail, provide address: \_\_\_\_\_

*I understand that standard email and text messaging may not be secure and carry a risk of being intercepted by unauthorized parties. By checking 'Yes,' I elect to receive communications via these methods despite these security risks.*

**2. CONTACT PERMISSIONS:** Can you be contacted at your place of employment?

YES  NO  NOT EMPLOYED

**3. CONSENT FOR AUTOMATED CONTACT:** I consent to receive automated calls, emails, and texts from LCO (Arcis Healthcare) regarding my PHI, appointments, and billing at any number provided. Standard rates may apply. This voluntary consent is not a condition of treatment and may be revoked at any time (reply 'STOP' to opt out of texts).

YES  NO

**Right to Revoke:** You have the right to revoke this authorization at any time by submitting a written request to the Privacy Officer. Revocation will not apply to information already released in reliance on this authorization.

**4. AUTHORIZED PERSONAL REPRESENTATIVES:** The following people have my permission to speak with LCO regarding my treatment/care plan or financial account:

Name	Relationship	Patient Initials

**5. E-PRESCRIBING & PRIVACY OFFICER CONTACT:** LCO uses e-prescribing software to securely access your 13-month medication history to enhance patient safety. We are legally required to follow our current Privacy Notice. LCO uses robust security measures to safeguard the confidentiality and integrity of information processed through Artificial Intelligence (AI) dictation. These measures include encryption, access controls, and regular security audits to prevent unauthorized access and protect against data breaches. For information or to report a privacy concern, contact our Privacy Officer, Bachi Evangelist, at (843) 797-5050.

Patient Name: \_\_\_\_\_

This authorization remains in effect for one (1) year from the date of signature unless a different expiration is specified here: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athena ID: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Primary Care Provider (PCP): \_\_\_\_\_

Pharmacy & Location: \_\_\_\_\_ Did you Receive a Flu Vaccine? Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Surgical Procedures: \_\_\_\_\_

<b>Weight</b>		<b>Lbs.</b>
<b>Height</b>	<b>Ft.</b>	<b>In.</b>

Medications (if you have a list, please give to Medical Assistant, and skip this): \_\_\_\_\_

FAMILY HISTORY: Please circle any that your parent was diagnosed with							
<b>Father</b>	Arthritis	Asthma	Cancer	Stroke	Diabetes	HIV/AIDs	Sickle Cell/
	Kidney Disease	Mental Disorder	Bleeding Disorder	Heart Attack	High Blood Pressure	High Cholesterol	Trait
<b>Mother</b>	Arthritis	Asthma	Cancer	Stroke	Diabetes	HIV/AIDs	Sickle Cell/
	Kidney Disease	Mental Disorder	Bleeding Disorder	Heart Attack	High Blood Pressure	High Cholesterol	Trait

SOCIAL HISTORY: Please circle the answer that best describes you					
<b>Smoking Status</b>	Never Smoke		Former Smoker		Currently smoke
<b>Smoking</b>	½ pack/day	1 pack/day	1.5 pack/day	2 pack/day	2 + pack/day
<b>Medical Power of Attorney</b>	Yes	No	<b>Advance Directive/ Living Will</b>	Yes	No
<b>Alcohol Intake</b>	None	1-4 drinks/week		5-9 drinks/week	> 10 drinks/week
<b>Marital Status</b>	Married	Single	Divorced	Separated	Widowed Domestic Partner
<b>Work History</b>	Disabled	Homemaker		Retired	Student Unemployed
<b>Current Job</b>			<b>Employer</b>		
<b>Hand Dominance</b>	Right Handed			Left Handed	

MEDICAL HISTORY: Please circle all conditions you have been diagnosed with					
Acid Reflux	Coronary Artery Disease	Glaucoma	Kidney Disease	Osteoporosis	Sickle Cell Anemia
Anemia	Chronic Bronchitis	Gout	Kidney Failure	Pacemaker	Sleep Apnea
Arthritis	Depression	Heart Attack	Kidney Stones	Panic Attack	Stroke
Asthma	Diabetes	Heart Disease	Leg/Foot Ulcers	Vascular Disease	Thyroid Problem
Anxiety	High Cholesterol	Hepatitis	Liver Disease	Phlebitis	Tuberculosis
Blood Clots	Emphysema / COPD	Hernia	Lung Disease	Poor Circulation	Ulcers
Bleeding Disorder	Fibromyalgia	High Blood Pressure	Mental Disorder	Pulmonary Embolism	Urinary Tract Infection
Blood Transfusion	Fracture	HIV/AIDs	MRSA/VRE	Rheumatoid Arthritis	
Cancer	Gallbladder Trouble	Insomnia	Migraines	Seizures / Epilepsy	

Review of Symptoms: (PLEASE CIRCLE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING)	
<p><b>Constitutional:</b> Fever Night Sweats Weight Gain Weight Loss Difficult exercising</p> <p><b>Eyes:</b> Dry eyes Irritation Change in vision</p> <p><b>Ears:</b> Difficult hearing Ear pain</p> <p><b>Nose:</b> Frequent nosebleeds Nose/sinus problems</p> <p><b>Mouth/Throat:</b> Sore throat Bleeding Gums Teeth problems Mouth ulcers Oral Abnormalities Snoring Dry Mouth</p> <p><b>Cardiovascular:</b> Chest pain Heart Murmur Palpitations Shortness of Breath when Walking Arm pain or exertion Shortness of Breath when Lying Down</p> <p><b>Gastrointestinal:</b> Abdominal pain Vomiting Loss of appetite Diarrhea Vomiting blood</p> <p><b>Genitourinary:</b> Incontinence Difficult Urinating Blood in urine Painful Urination Increase urinary frequency</p>	<p><b>Musculoskeletal:</b> Muscle aches Muscle Weakness Back pain Joint pain Swelling in extremities</p> <p><b>Skin:</b> Abnormal Mole Jaundice Rash Itching Dry Skin Growth/lesions</p> <p><b>Neurologic:</b> Loss of consciousness Weakness Numbness Seizures Dizziness Headaches Migraines Restless legs</p> <p><b>Psychiatric:</b> Depression Sleep Disturbance Alcohol abuse</p> <p><b>Endocrine:</b> Fatigue Increased Thirst Hair loss Increased hair growth Cold intolerance</p> <p><b>Hematologic/Lymphatic:</b> Swollen glands Easy Bruising Excessive bleeding</p> <p><b>Allergic/Immunologic:</b> Runny nose Sinus Pressure Itching Hives Frequent sneezing</p> <p><b>Respiratory:</b> Coughing Wheezing Shortness of breath Coughing up blood</p>